NEWS RELEASE

UNITED STATES CIVIL SERVICE COMMISSION

WASHINGTON 25, D.C.

NEWS UNIT
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Room 269
Eighth and F Streets NW

FOR RELEASE:

The Civil Service Commission announced today that it has approved the benefits and the premium rates of the 37 plans that will participate in the Federal Employees Health Benefits Program during the next contract year, which begins in November. Of the 37 plans, three are participating in the program for the first time.

For about 94 percent of the persons already enrolled in the program, there will be no increase in rates with some liberalization of benefits for the next contract period, the Commission said. However, benefit and rate changes made by the plans which participated in the program during the first contract period depend on their present benefit structures and were based on the experience of each plan during the first nine months of operation. The changes do not follow a uniform pattern. For example, there were both increases and decreases in deductibles.

Of the 34 plans continuing in the program, 28 made changes in benefits. In general, the changes improve the benefits to be offered. The Commission noted that many of the changes in benefits made by the plans are the result of an around-the-world survey which CSC conducted to obtain employee reaction to the plans. After the information was gathered and summarized it was furnished to the carriers and also used in connection with the negotiation of the new contracts.

Fourteen of the 34 continuing plans made some increase in their rates, while one plan reduced its rate for the high option. Calculated on a biweekly basis, the increases ranged from a few cents to more than a dollar. Rate changes follow no general pattern; of the plans offering two options, some made increases in both options: others made it in the high option or low option only. Some plans that had only one level of benefits made increases in both individual and in self-and-family rates, while others increased the family rate only.

A breakdown of the rate changes by plan category shows: the two Government-wide plans made no increase in rates; three of the 12 employee organization plans made biweekly increases in rates ranging from 14 cents to 47 cents for self-only enrollments and from 49 cents to $1.24 for self-and-family enrollments, while one employee organization plan reduced its high option rates by 32 cents; 11 of the 23 comprehensive medical plans made biweekly increases

in their rates ranging from 4 cents to 58 cents for self-only enrollments an from 8 cents to $1.61 for self-and-family enrollments. None of the comprehensive plans decreased their rates.

The rate changes are expected to result in a relatively small increase in the total cost of the Health Benefits Program, the Commission said. What increase does result will be borne by the enrollees. There will be no increas in the Government contribution for the next contract period.

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(Note to Editors: Details on changes made in individual plans are attached.)

Bureau of Retirement and Insurance

United States Civil Service Commission

Washington, D. C.

August 7, 1961

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The following participating plans are making no changes in their benefits or rates:

Bridge Clinic, Seattle, Washington

Community Health Association, Detroit, Michigan (new plan)

Medical Guild Health Plan, San Francisco, California (formerly Ray E. Harris, M.D. and Staff)

National Hospital Association, Portland, Oregon

Physicians Association of Clackamas County, Oregon City, Oregon (new plan)

Seguros De Servicio De Salud De Puerto Rico, Inc., Puerto Rico (new plan)

Special Agents Mutual Benefit Association (SAMBA)

Participating health benefit plans which are making changes effective in November 1961 follow:

CHANGES IN THE GOVERNMENT-WIDE HEALTH BENEFITS PLANS EFFECTIVE BY NOVEMBER 1961

GOVERNMENT-WIDE SERVICE BENEFIT PLAN

Benefits

The maximum Supplemental Benefit is now $30,000 rather than $20,000 under the High Option, and $10,000 rather than $5,000 under the Low Option.

Even though the usual deductible has not been met, Supplemental Benefits are now provided for certain diagnostic tests (including X-ray) in a physician's office or in a hospital outpatient department for charges in excess of $20 (High Option) and $25 (Low Option) in a Benefit Period.

Services of licensed practical nurses are now covered under certain circumstances.

The provision which ended a Supplemental Benefit Period if a subscriber had no covered expenses for over 90 days has been eliminated. A Benefit Period will now continue for 12 consecutive months.

Basic Benefits for a physician's charge for emergency first-aid treatment within 72 hours of an accident are now provided even when surgery is not involved.

A benefit is now provided for removal of a cast or of sutures for lacerations by a physician other than the one who applied them when the Carrier determines that the services of the second physician are necessary.

Benefits are now payable for covered services provided by doctors of surgical chiropody (D.S.C.).

The benefits for cesarean delivery and for miscarriage are now increased.

A separate payment under Maternity Benefits is now made for the administration of an anesthetic when provided as a regular hospital service.

The Supplemental Benefits Deductible under the Low Option is now $150 rather than $200 for each person each Benefit Period.

The $500 limitation on eligible expenses for special nursing care under the Low Option Supplemental Benefits has been removed.

Supplemental Benefits payable under the Low Option for the treatment of nervous or mental disorders are expanded to include treatment in mental hospitals and in outpatient and out-of-hospital facilities.

Rates

Rates for this Plan will remain the same.

GOVERNMENT-WIDE INDEMNITY BENEFIT PLAN

Benefits

The first $30 for out-of-hospital prescription drugs and medicines is no longer excluded and is now an allowable expense.

For the Low Option, the amount of Hospital Room and Board expenses for which benefits are payable at 100 percent has been raised to $500.

The double coverage provision now permits you to receive up to 100 percent of your total allowable expenses.

Doctors' charges are now allowable for cutting out impacted teeth that are not completely erupted.

Charges of licensed practical nurses are allowable under certain conditions.

Certain Christian Science services are now recognized.

Podiatrists' charges are now allowable for treatment of covered foot conditions.

Certain services of psychologists are now recognized.

The list of "severe complications of pregnancy" has been expanded, and the more liberal regular benefits (instead of maternity benefits) are now payable for the expenses of the pregnancy itself as well as for those of the severe complication.

Benefits for Maternity Expenses no longer provide a separate allowance for the anesthetist.

Hospital charges for custodial care are no longer allowable expenses.

Benefits for out-of-hospital psychiatric treatment are now limited to no more than $250 per person, per calendar year, and benefits for such expenses incurred prior to November 15 count toward this limit.

Rates

Rates for this Plan remain the same.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES HEALTH BENEFIT PLAN

Benefits

High Option

The Plan now pays 100 percent of the first $250 of Hospital Miscellaneous charges in a calendar year.

The $75 Deductible for out-of-hospital expenses has been reduced to $50.

The Plan now pays 100 percent of the first $150 in a calendar year of hospital charges for emergency care or outpatient surgery.

The conditions which will be considered as severe complications of pregnancy have been extended.

The amount of the Maximum Benefit has been increased to $30,000.

Low Option

The number of days of confinement for which Hospital Benefits are payable has been increased from 60 to 90 days.

High and Low Option

The definition of doctor has been expanded to include licensed dental surgeons and podiatrists for certain services.

The Double Coverage provision now permits a covered person to receive up to 100 percent of total covered expenses.

Rates

Rates for this plan remain the same.

CANAL ZONE HEALTH BENEFIT PLAN

Benefits

In Canal Zone and Panama hospitals, the Plan now pays up to $12 per day for room and board, up to $5 per day for doctors' services in non-surgical cases, and in Canal Zone hospitals only, up to $2 per day for laboratory services in all cases.

In hospitals outside the Canal Zone or Panama, the Plan now pays up to $20 per day for room and board and up to $5 per day for doctors' services in non-surgical cases.

Maternity Benefits have been increased to pay actual charges up to $177 instead of $135.

The Plan no longer provides coverage on a coinsurance basis without a deductible for hospital and surgical charges after the 70th day of confinement; however, it now provides Major Hospital and Surgical Benefits for hospital and surgical expenses on a coinsurance basis after the Plan has paid Basic Benefits of more than $500 and after you pay $100 of hospital charges and surgical expenses not covered under the basic benefits of the Plan.

The Plan now pays up to $150 instead of $75 for miscellaneous hospital expenses for each hospital admission during confinement in the Canal Zone or Panama and up to $200 instead of $75 for such expenses outside the Canal Zone or Panama.

The Plan will now pay actual charges in an outpatient department of a hospital up to $25 in case of accidental injury.

The maximum payment for surgery in the Canal Zone or Panama will now be the new increased List Rate specified in the Canal Zone Medical Tariff. Also the Plan will now pay up to twice the List Rate specified in the Canal Zone Medical Tariff for surgery outside the Canal Zone or Panama.

Rates

Rates for this Plan will be increased. The increase in the biweekly cost will be 47 cents for a self only enrollment, $1.24 for a self and family enrollment and $1.65 for a self and family - female and nondependent husband.

Benefits

The Plan will now pay benefits for dental work necessary for prompt repair of accidental injury to natural teeth.

Hospital expenses in connection with oral surgery or dental work are now covered even if the doctor's charges for these services are not.

A podiatrist's charges for treatment of certain conditions of the foot are now covered.

The Plan now limits benefits if benefits are also payable under certain other plans.

Rates

Rates for this Plan remain the same.

FOREIGN SERVICE HEALTH BENEFIT PLAN

Benefits

The Double Coverage provision now permits an enrollee to receive up to 100 percent of total covered expenses.

Podiatrist's charges are now covered for treatment of certain foot conditions.

The conditions which will be considered as severe complications of pregnancy have been extended.

Charges of a dental surgeon (D.D.S.) for certain services are now covered.

Rates

Rates for this Plan remain the same.

MAINTENANCE EMPLOYEES HEALTH BENEFIT PLAN

Benefits

Under the High Option, the number of days of Hospital Room and Board coverage is increased to 120 days.

The period of time during which a covered person must be out of a hospital between admissions in order for the later admissions for the same illness or accident to be considered as a new period of confinement, has been reduced to 60 consecutive days. This change applies to both options

Under the High Option, the Maternity Benefit is increased to a maximum of $190.

Under the High Option, the Plan will now pay 75 percent, instead of 50 percent, of Hospital Miscellaneous expenses after the first $300, up to a maximum payable by the Plan of $1,000.

Both Options will now pay regular benefits, instead of Maternity Benefits, in cases of certain complications of pregnancy.

Under the High Option, the maximum payable for Out-of-Hospital X-ray and laboratory examinations is increased to $50 each insurance year.

Rates

Rates for this plan remain the same.

MOTOR VEHICLE EMPLOYEES HEALTH BENEFIT PLAN

Benefits

Under the High Option, the number of days of Hospital Room and Board coverage is increased to 120 days.

The period of time during which a covered person must be out of a hospital between admissions in order for the later admission for the same illness or accident to be considered as a new period of confinement, has been reduced to 60 consecutive days. This change applies to both options.

Under the High Option, the Plan will now pay 75 percent, instead of 50 percent, of Hospital Miscellaneous expenses after the first $300, up to a maximum payable by the Plan of $1,000.

Under the High Option, the maximum payable for Out-of-Hospital X-ray and laboratory examinations is increased to $50 each insurance year.

Rates

Rates for the Low Option of this plan remain the same. Rates for the High Option will increase. The increase in the High Option, biweekly cost will be 29 cents for a self only enrollment and 49 cents for a self and family enrollment.

Benefits

Services of a podiatrist for certain conditions of the foot are now covered by this Plan.

The Plan now covers certain miscellaneous expenses when a surgical procedure is performed in a doctor's office.

Oral surgery is now allowed only when performed by a doctor of medicine (M.D.).

To be covered by the Plan, cosmetic surgery necessary for repair of accidental injury must now be initiated within 6 months of the accident causing the injury, and the accident must occur while covered by this Plan.

To be covered by the Plan, dental work and dental surgery necessary for repair of accidental injury to sound natural teeth must now be initiated within 6 months of the accident causing the injury and the accident must occur while covered by this Plan.

Transportation to and from a hospital is now limited to local ambulance service.

Premature birth and miscarriage are no longer considered complications of pregnancy.

The enrollee must now pay the first $200 of any surgical charges which exceed the allowance in the surgical fee schedule before the Plan will pay any additional surgical benefits.

The Plan now limits its benefits in case benefits are also payable under any other health benefits plans.

Covered expenses of hospital confinement for tuberculosis and mental and nervous disorders are limited to the first 30 days (HIGH OPTION) in a "period of treatment" and the first 14 days in a "period of treatment" (LOW OPTION).

Rates

Rates for this plan remain the same.

NATIONAL POSTAL UNION HEALTH BENEFIT PLAN

Benefits

Under Basic Benefits the total allowance for administration of anesthetics by other than a hospital employee has been increased from $25 to $40 under both options.

Under Basic Hospital Benefits of both options, the Plan will now pay for use of out-patient operating room and for ambulance service.

For private accommodations in a hospital, the maximum allowance under Basic Benefits of both options has been increased from $10 to $20 per day.

The maximum allowance for hospital expenses for normal maternity has been increased from $120 to $150 under the High Option and $125 under the Low Option. Allowances for doctors' services in connection with maternity have been increased to $100 under the High Option and to $75 under the Low Option.

In case of confinement during pregnancy, but before delivery for a condition arising out of pregnancy, the maximum daily hospital allowance has been increased from $12 to $15.

Hospital benefits for removal of tonsils and adenoids are no longer limited to one day.

Basic hospital benefits for mental and nervous disorders will now be paid up to 20 days under the Low Option and 30 days under the High Option for confinements in a general hospital.

The maximum surgical benefit has been increased from $250 to $300 under the Low Option and $400 under the High Option. Also, the High Option now will pay 80% of any reasonable and customary charges which exceed the amount listed in the Schedule of Operations.

The maximum yearly allowance for X-ray and laboratory expenses has been increased from $30 to $40 under the Low Option and to $50 under the High Option.

The first aid benefit for out-patient emergency treatment after accidental injury is now payable if treatment is administered within 48 hours after the accident, instead of the previous 24-hour limitation.

The High Option deductible for Major Medical Benefits has been decreased from $100 to $50; also, the coinsurance rate has been increased from 75% to 80%.

A Major Medical Benefits feature has been added to the Low Option; this benefit will pay 50% of covered expenses after a $200 deductible has been satisfied up to a maximum Major Medical Benefits payment of $5,000.

The percentage of expenses for mental or nervous disorders that will be considered covered expenses for Major Medical Benefits has been increased from 50% to 62½%.

The maximum covered expense for private accommodations in a hospital under Major Medical Benefits has been increased from $15 a day to $30 a day. The double coverage provision has been extended so that the amount of any benefit paid under any other health insurance plan will be deducted from the enrollee's expenses before he receives benefits under this Plan.

The limitation on basic hospital benefits for Poliomyelitis has been removed and regular basic benefits are now paid.

Rates

Rates for the Low Option of this Plan will remain the same. Rates for the High Option will be reduced. The decrease in the High Option biweekly cost will be 32 cents for a self only enrollment and 32 cents for a self and family

POSTMASTERS HEALTH BENEFIT PLAN

Benefits

The number of days of Hospital Room and Board coverage is increased to 120 days under the High Option, and 100 days under the Low Option.

Under the High Option, if a private room is used during the first 120 days of confinement, and the hospital's regular semiprivate room rate is less than $16 a day, the Plan will pay the actual charge for private accommodations, up to $16 a day.

Under the High Option, the first $50 for out-of-hospital X-ray and laboratory examinations, and the first $25 for first-aid treatment for accidents will now be paid.

The Plan will now pay regular benefits, instead of Maternity Benefits, in case of certain complications of pregnancy.

The period of time during which a covered person must be free of confinement between admissions for the same cause, in order for the later admission to be considered a new confinement, has been reduced from 70 to 60 consecutive days.

Rates

Rates for this Plan remain the same.

RURAL CARRIER HEALTH BENEFIT PLAN

Benefits

The number of days of Hospital Room and Board coverage is increased to 120 days under the High Option, and 100 days under the Low Option.

Under the High Option, the additional $10,000 payable for Hospital Miscellaneous expenses after the first $300 now also includes Hospital Room and Board expenses after the 120th day of confinement (with a maximum payable for Room and Board charges of $20 per day).

Under the High Option, if a private room is used during the first 120 days of confinement, and the hospital's regular semiprivate room rate is less than $16 a day, the Plan will pay the actual charge for private accommodations, up to $16 a day.

Under the Low Option, the maximum surgical benefit is increased to $300.

Under the High Option, the first $50 for out-of-hospital X-ray and laboratory examinations, and the first $25 for first aid treatment for accidents will now be paid by the Plan.

The Plan will now pay regular benefits, instead of Maternity Benefits, in case of certain complications of pregnancy.

The period of time during which a covered person must be free of confinement between admissions for the same cause, in order for the later admission to be considered a new confinement, has been reduced from 70 to 60 consecutive days.

Rates

Rates for this plan remain the same.

This Plan differs considerably from that previously offered by the United Federation of Postal Clerks (formerly the National Federation of Post Office Clerks) under the Federal Employees Health Benefits Act of 1959.

Benefits

The Plan no longer has a deductible. However, the first $30 of out-of-hospital drugs and medicines, appliances, and equipment are not covered.

Hospital expenses (including supplies and services as well as room and board) are now payable in full for up to 180 days under the High Option and 120 days under the Low Option, plus a stated percentage of additional expenses.

The Plan now pays Surgical Benefits in accordance with a Schedule of Operations (maximum fee, $300); the High Option also pays 80% of any reasonable and customary charge exceeding the amount allowed by the schedule.

The maximum amounts payable for Maternity Benefits have been increased to $280 for the High Option and $200 for the Low Option.

Charges for podiatrists' services are now covered for certain specified conditions.

Benefits for mental and nervous disorders, tuberculosis and polio are now limited.

There are now maximum benefits for doctors' services (other than surgery), special nursing service, first-aid treatment, and out-of-hospital diagnostic services.

The **Low Option** no longer provides benefits for private duty nursing care, or drugs, appliances or equipment, The **High Option** does provide such benefits.

Rates

Rates for the Low Option of this plan will remain the same. Rates for the High Option will be increased. The increase in the High Option, biweekly cost will be 14 cents for a self only enrollment and 92 cents for a self and family enrollment.

CHANGES IN COMPREHENSIVE MEDICAL PLANS EFFECTIVE IN NOVEMBER, 1961

CALIFORNIA COUNTIES MEDICAL SOCIETIES' FOUNDATION FOR MEDICAL CARE, STOCKTON, CALIFORNIA

Benefits

The Service Area, within which full benefits of the Plan are provided, has been reduced.

Out-of-Area Benefits have been increased to provide additional benefits for medical and surgical care.

Benefits for laboratory tests and diagnostic X-rays are now limited to $150 per membership year for all services in or out of a hospital.

No benefits are now provided for services of non-Foundation doctors within the Service Area (except for a $100 emergency benefit).

Rates

Rates for family enrollment in the Plan will be increased. The increase in the biweekly cost of a self and family enrollment will be 48 cents.

GROUP HEALTH ASSOCIATION OF WASHINGTON, D. C.

Benefits

Out-of-Service-Area benefits have been broadened and certain limitations removed.

Prescribed drugs and medicines benefit (High Option only) has been changed from a $25 deductible to a $50 deductible.

For Low Option only there is a $2 service charge for medical center doctor consultation.

Rates

Rates for the Low Option remain the same. Rates for the High Option will be increased. The increase in the High Option biweekly cost will be 57 cents for a self only enrollment and $1.20 for a self and family enrollment.

Benefits

The service charge for complete maternity care has been increased from $125 to $135.

Out-of-Area Benefits have been increased from $250 to $500; the higher benefit includes an allowance for special transportation to return an individual to the Seattle area for treatment by GHC.

Rates

Rates for the Plan will be increased. The increase in the biweekly cost will be 37 cents for a self only enrollment and $1.15 for a self and family enrollment.

GHI FAMILY DOCTOR PLAN, NEW YORK, N. Y.

Benefits

Allowances, which are accepted by participating doctors as full payment, are now paid for services of private anesthetists in connection with in-hospital surgery or maternity care.

Special benefits are now provided for private-duty nursing service, prescribed drugs and medicines used out of the hospital, ambulance service, oxygen, and corrective appliances.

Rates

Rates for this Plan will be increased. The increase in the biweekly cost will be 44 cents for a self only enrollment and $1.44 for a self and family enrollment.

GROUP HEALTH PLAN OF ST. PAUL, MINNESOTA

Benefits

This Plan has been modified to include both a High and a Low Option.

Benefits under the present Low Option are the same as were provided in last year's single-option Plan.

The High Option that has been added provides the same Medical and Surgical Benefits as the Low Option.

High Option Hospital Benefits and Out-of-Area Benefits are more extensive than under the Low Option.

Rates

Rates for the Low Option (last year's Plan) remain the same. The total biweekly cost to a person enrolled in the High Option will be $2.96 for a self only enrollment, $7.40 for a self and family enrollment, and $8.70 for a self and family - female and nondependent husband.

HAWAII MEDICAL SERVICE ASSOCIATION, HONOLULU, HAWAII

Benefits

The maximum Major Medical Benefit has been increased from $7,500 to $10,000.

Allowable charges for room and board under Basic Hospital Benefits are now limited to $18.50 a day.

The maximum that may be charged to the member by a participating doctor for the first office visit in each separate condition is now $1 instead of $2.

The number of days of hospitalization for each separate illness or injury provided under Basic Hospital Benefits has been increased from 120 to 135.

Fee schedule allowances payable for services of non-participating doctors have been increased for all surgical procedures and for many of the allowable medical services.

Rates

Rates for family enrollment in this Plan will be increased. The increase in the biweekly cost of a self and family enrollment will be 60 cents.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

Benefits

The Plan now has two options, a Low Option comparable to the coverage offered prior to November 1961, and a High Option. The options differ only in the number of days of hospital care provided.

The maximum indemnity for non-H.I.P. physicians' fees incurred for the treatment of medical emergencies in a hospital has been increased from $150 to $350, and has been extended to cover physicians' care out of hospital when required within 24 hours of an accidental injury.

Rates

Rates for the Low Option of the Plan will be increased but the exact amounts are not yet known.

KAISER FOUNDATION HEALTH PLAN -- HAWAII REGION

Benefits

The $2 charge for each additional family member treated during the same home call has been eliminated. All home calls are now $5 each, regardless of the number of covered persons treated by the doctor.

Rates

Rates for the Plan will be increased. The increase in the biweekly cost will be 42 cents for a self only enrollment and $1.61 for a self and family enrollment.

KAISER FOUNDATION HEALTH PLAN -- NORTHERN CALIFORNIA REGION

Benefits

There are no changes in this Plan's benefits.

Rates

Rates for the Plan will be increased. The increase in the biweekly cost will be: In the Low Option, 17 cents for a self only enrollment and 57 cents for a self and family enrollment; in the High Option, 18 cents for a self only enrollment and 73 cents for a self and family enrollment.

KAISER FOUNDATION HEALTH PLAN OF OREGON

Benefits

Full benefits are now provided for congenital conditions customarily treated by KFH Plan doctors at KFH Plan facilities; the $250 limitation still applies to congenital conditions not customarily treated by KFH Plan doctors at KFH Plan facilities.

Maternity benefits are now provided only for employees or employees' wives covered under family enrollments.

Maximum benefits for services received outside the Service Area of the KFH Plan have been increased from $500 to $750.

Rates

Rates for the Plan will be increased. The increase in the biweekly cost will be 28 cents for a self only enrollment and 76 cents for a self and family enrollment.

KAISER FOUNDATION HEALTH PLAN -- SOUTHERN CALIFORNIA REGION

Benefits

Hospital Benefits are now provided on a calendar year basis, regardless of the number of illnesses or injuries involved, instead of on the basis of each illness or injury each year.

The charge for full maternity care under the High Option will be increased from $60 to $100 and the charge under the Low Option will be increased from $125 to $150; the maximum charge for miscarriage will be increased from $40 to $67 under the High Option and from $84 to $100 under the Low Option.

Rates

Rates for the Plan will be increased. The increase in the biweekly cost will be: In the Low Option, 8 cents for a self only enrollment and 28 cents for a self and family enrollment; in the High Option, 4 cents for a self only enrollment and 26 cents for a self and family enrollment.

NORTH IDAHO DISTRICT MEDICAL SERVICE BUREAU PLAN, LEWISTON, IDAHO

Benefits

Hospital Benefits have been liberalized to cover each illness, injury, or condition each membership year.

Nonparticipating physicians' services within the Service Area are provided at the fee schedule allowances without the previous requirement of authorization by a participating doctor and approval by the Bureau.

Rates

Rates for this Plan remain the same.

PHYSICIANS & SURGEONS ASSOCIATION, LOS ANGELES, CALIFORNIA

Benefits

A $1 service charge has been added for visits to the medical group's office.

Treatment of congenital conditions is now excluded.

Rates

The Low Option has been dropped from this Plan. Rates for this Plan remain the same as the previous high option rates.

ROSS-LOOS MEDICAL GROUP, LOS ANGELES, CALIFORNIA

Benefits

The service charges up to $25 for surgery and the charges for out-of-hospital laboratory tests, X-ray examinations, and radiation therapy have been eliminated; the enrollee now pays nothing for these services.

The Special Polio Benefit has been increased from $3,000 to $7,500.

The maximum benefit for hospital services (other than room and board) has been increased from $1,100 to $2,300 for each disability.

Rates

Rates for this Plan remain the same.

SEATTLE LETTER CARRIERS MEDICAL SERVICE PLAN, SEATTLE, WASHINGTON

Benefits

Special allowances for administration of anesthetics are now provided under Maternity Benefits.

The Plan now covers charges for blood plasma and blood derivatives (but not whole blood).

Additional items have been added to the fee schedule.

Rates

Rates for this Plan remain the same.

WASHINGTON PHYSICIANS SERVICE, SEATTLE, WASHINGTON

Benefits

The service charge for doctors' visits has been reduced from $2.00 to $1.50.

Hospital Benefits have been liberalized to cover each illness, injury, or condition each membership year.

Rates

Rates for this Plan remain the same.

WESTERN CLINIC PLAN, TACOMA, WASHINGTON

Benefits

There are no changes in this Plan's benefits.

Rates

Rates for the Plan will be increased. The increase in the biweekly cost will be 58 cents for a self only enrollment and $1.36 for a self and family enrollment.

BTN. NO. 890-4 (Errata)

UNITED STATES CIVIL SERVICE COMMISSION

BULLETIN

Washington 25, D. C.
August 1, 1961

BULLETIN NO. 890-4 (Errata)

SUBJECT: Federal Employees Health Benefits Program:
Open Season - General Instructions

Heads of Departments and Independent Establishments:

The following are changes to be made in FPM Bulletin 890-4:

In the last two lines of paragraph VIII B on page 9, strike "but not less than seven (7) days***", substitute the word "and" for them, and add three asterisks (***) at the end of the sentence.

In the note marked with three asterisks (***) at the top of page 10, substitute for the first sentence the following: "The present 14-day wait required by the Group Health Benefits Regulations will be eliminated November 1."

Warren B. Irons
Executive Director

INQUIRIES: Regional Office or Bureau of Retirement and Insurance
Dudley 6-3391 or 6-3333 (Code 129, Extension 3391 or 3333).

CODE: 890-Group Health Insurance

DISTRIBUTION: FPM
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BULLETIN EXPIRES October 16, 1961

BTN. NO. 890-4 (1)

UNITED STATES CIVIL SERVICE COMMISSION

BULLETIN

Washington 25, D. C.
August 1, 1961

BULLETIN NO. 890-4

SUBJECT: FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: OPEN SEASON--GENERAL INSTRUCTIONS

Heads of Departments and Independent Establishments:

In Departmental Circular No. 1024, Supplement No. 8, which explained the procedures to be observed in last years's enrollment for health benefits, I said that, "It is impossible to anticipate all the situations which can and will arise during the initial enrollment and cover them with specific procedural instructions. The Commission is confident that employing and payroll offices will, as necessary and within the framework of the attached instructions, improvise upon them to meet the unique or unanticipated situations in order to fulfill /our/ objectives."

Our confidence was more than justified by the resourcefulness with which agencies handled the huge job of enrolling nearly 2,000,000 employees and their 3,000,000 family members.

I again ask that employing and payroll offices apply the ingenuity which will be needed to efficiently fulfill the objectives of the open season -- to give every employee who wishes to do so a chance to change his health benefits election, to promptly inform carriers of those changes which are made, and to adjust payroll withholdings and contributions promptly so that carriers receive their premium on time and in the correct amounts.

The attached instructions governing the open season deal largely with principles. Many details are left to be worked out by each agency as best suits its own situation. Through later Bulletins, we will keep

INQUIRIES: See last paragraph.

CODE: 890-Group Health Insurance

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you informed of developments as planning for the open season progresses. In the meantime, if information or assistance is needed, it may be obtained in the Washington Metropolitan area by calling Code 129, Extension 3391 or 3333, and in the field by calling the Commission's Health Benefits Representative at the Commission's Regional Office.

Warren B. Irons
Executive Director

Attachment

Attachment to BTN. NO. 890-4 (1)

INSTRUCTIONS

GOVERNING

OPEN SEASON

OCTOBER 1 - 16, 1961

Bureau of Retirement and Insurance
U. S. Civil Service Commission
Washington 25, D. C.

Approved For Release 2009/08/28 : CIA-RDP87-00868R000100080027-9

Attachment to BTN. NO. 890-4 (2)

I. AUTHORITY

The Group Health Benefits Regulations as amended will provide for an open season as follows:*

Section 89.3(f)(1). An employee eligible to register who has failed to register within the time limits prescribed, who is registered not to be enrolled, or who has cancelled his enrollment, may register to be enrolled between the 1st and 16th, inclusive, of October, 1961.

(2) An enrolled employee or annuitant may change his enrollment with respect to whether his family is covered, the health benefits plan in which he is enrolled, which of the options he selects, or any combination of these, between the 1st and 16th, inclusive, of October, 1961.

(3) Thereafter, not less often than once every three years, the Commission will by regulation provide every employee a similar opportunity for enrollment and change of enrollment, on such terms and conditions as it may prescribe.

Section 89.4 (b) (1). The effective date of enrollment under section 89.3(f)(1) for employees who are not enrolled in a health benefits plan is the first day of the first pay period after October 31, 1961, which follows a pay period during any part of which the employee is in pay status except that, if the employee is a substitute in the postal field service, the effective date must follow six consecutive pay periods in which the employee was in pay status and in each of which he drew sufficient pay, after other deductions, to permit withholding of the amount necessary for his share of the cost of the health benefits plan he selects.

(2) The effective date of change of enrollment under section 89.3(f)(2), for employees and annuitants who are enrolled in a health benefits plan, is the first day of the first pay period after October 31, 1961.

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*Prior to October 1, 1961, the regulations will be amended to so provide.

II. PURPOSE

The purpose of the open season regulation is to provide every employee eligible under the regulation quoted on page one, an unrestricted opportunity to change his mind (and election) about his health benefits coverage or lack of it.

The open season coincides with the expiration of the Commission's existing contracts with carriers. These contracts are being renegotiated and some changes will be made in practically every participating plan. Therefore, a by-product of the open season will be to give each enrollee a revised brochure containing an up-to-date statement of the benefits to which the new contract entitles him if he remains in his present plan.

III. OPPORTUNITY TO REVIEW BROCHURES

In addition to benefit changes in most plans and subscription charge changes in some, two plans will discontinue participation and several new group- and individual-practice plans (available only in limited geographic areas) have been approved for participation in the Health Benefits Program. New plans and those discontinuing participation will be announced later.

Therefore, as during the initial registration period in June of last year, every employee eligible to change his election during the open season must be given an opportunity to review the revised brochures on all plans available to him and decide whether he wishes to make a change.

Revised brochures will be distinguishable from previous editions because they will be printed on light green paper. Previous editions of all brochures will become obsolete on November 1, 1961, and should then be destroyed.

IV. AGENCY RESPONSIBILITY TO INFORM EMPLOYEES

As explained in VII, following, agencies are responsible for distribing new brochures on the various plans to all employees eligible to change their election and for "counselling" them -- i.e., announcing in house organs or through other means, the dates and purpose of the open season, and answering questions about the application of specific provisions of the health benefits law, regulations, and brochures to particular circumstances.

Here is a suggested text of an announcement which may be adapted for publication in house organs, posting on bulletin boards, etc.

Attachment to BTN. NO. 890-4 (4)

All employees of (name of Federal installation) enrolled in plans offered under the Federal Employees Health Benefits Program will have an opportunity to change their enrollments during the open season scheduled for October 1 through 16, 1961. In addition, eligible employees who did not enroll at their first opportunity will be able to enroll during this open season.

Changes enrolled employees may make are:

- Change from one health benefits plan to another
- Change from one option of a plan to the other
- Change from a self-only enrollment to a self-and-family enrollment or the reverse.

The (name of installation office making distribution) will distribute to each eligible employee an informational pamphlet on the open season and brochures on all health benefits plans for which employees at (name of Federal installation) are eligible. These plans include:

Government-wide Service Benefit Plan
Government-wide Indemnity Benefit Plan
(List all pertinent comprehensive medical plans)

Employees who are members of a Federal employee organization which sponsors a health benefits plan will receive brochures on their organization's plan through the mail direct from the Civil Service Commission. Employees who are not members of an employee organization but who are eligible to join one and desire to study the plan it offers may request a brochure on the plan from (name of person or office, room number, and phone number). Membership requirements for the various organizations are listed in the open season information pamphlet to be distributed to all employees.

Distribution of these materials will be made before the start of the open season on October 1, 1961.

Most plans are changing some of their benefit provisions and some plans are changing their premiums. Therefore, all employees will again want to read the brochures carefully.

Employees who do not desire to make any changes in their enrollment need take no action. Those who do want to change their enrollment, or who originally elected not to enroll but now wish to enroll, will need to complete a new Health Benefits Registration Form, (Standard Form 2809). (Explain here how and from whom employees may obtain the SF 2809.)

If, after studying the brochures, an employee has a question concerning his health benefit enrollment, he should contact (name of office or person) at (office location or telephone number or both).

SUGGESTION TO EMPLOYEES

1. Read the brochures carefully
2. If you decide to make NO change, do nothing
3. If you decide to make a change, obtain and complete Standard Form 2809
4. Submit the Completed SF 2809 to (name of office) before October 16

Part V of these instructions and the following excerpt from Departmental Circular 1024, Supplement No. 11, dated May 6, 1960, also apply in connection with counselling.

The Commission expects that employees will have questions to which they will need answers and recognizes the size of the task agencies face in this regard.

Nevertheless, there are definite limits to which either the Commission or the agencies can and should go in informing and counselling employees, especially in the area of comparing plans. As important as providing the employee a basis upon which to make an informed choice is the Government's responsibility to remain completely accurate and objective in presenting plans and to preserve the employee's right to arrive at the choice himself. It is to this point that the following Commission policy is addressed.

The Commission believes that the agencies' counselling responsibilities during the [open season] should be limited to:

(1) familiarizing employees with the program in general

(2) answering questions about the application of specific provisions of the Act, the regulations, and the brochures to particular circumstances

To the limit of its resources, the Commission will assist by trying to supply the answers to questions which are germane and of real and immediate significance.

V. TRAINING OF AGENCY REPRESENTATIVES

To enable agencies to discharge their counselling responsibility, the Commission plans to hold training sessions for agency representatives, beginning in mid-August. This training will be given in Washington and in the field and will include discussion of significant changes in the regulations, of changes in benefits being offered by carriers under their new contracts, and of procedures governing the open season.

Bulletin 890-3 of June 15, 1961, announces training plans for the Washington area, and Circulars issued by the Commission's Regional Offices announce sessions available to field installations.

As during the initial enrollment in 1960, training will be open to agency personnel who are assigned health benefits program responsibilities, including those who process registrations and those who counsel employees.

VI. PROMOTIONAL ACTIVITY PROHIBITED

As during the initial enrollment, agencies (and installations) should not permit the use of Government facilities or official time for unauthorized promotion or "explanation" of plans by carrier representatives. However, agencies may continue to permit controlled contact between a carrier representative and an employee already enrolled in that particular carrier's plan for purposes of helping the employee who has a claim or benefit question.

The following excerpts from Departmental Circular 1024, Supplement No. 3, February 9, 1960, and FPM Letter 890-2, February 15, 1961, still apply to promotional activity.

SUPPLEMENT NO. 3

Carriers of the various plans to be offered under the Health Benefits Program understand that they will not be permitted to make a personal appeal to employees. If it is offered, agencies should not accept "help" from a carrier's representative in explaining a plan or permit a carrier's representative to contact groups of employees for any purpose which directly or indirectly will permit or may be construed to permit solicitation for enrollment.

FPM LET. 890-2

The Civil Service Commission will not object if an agency, in its discretion, admits an authorized representative of a carrier to agency premises. However, any contact with a representative of a carrier on agency premises should be controlled by the agency and limited to agency personnel who have responsibility under the health benefits program and to individual employees who have claim or benefit questions about that carrier's plan. Where an agency believes that a meeting of a group of employees enrolled in a plan with a representative of that plan would best serve the employees' needs, such a meeting may be arranged by the agency. Group meetings should be the exception rather than the rule and should be confined to matters which are of general interest.

VII. DISTRIBUTION OF BROCHURES AND RELATED FORMS

A. In general. Distribution of brochures will be made in the same way as for last year's initial enrollment, i.e., the Commission will mail employee organization plan brochures direct to organization members, and agencies will distribute all other brochures direct to employees.

B. Health Benefits Registration Form (SF 2809). Only an employee who wishes to change his election during the open season will need to complete and file SF 2809. Therefore, installations should not make general distribution of SF 2809 to all employees. These forms should, however, be stocked in strategic places so that any employee who needs one to change his election can quickly obtain it.

Agencies which need additional supplies of SF 2809 should requisition them from the Commission in the usual way. Estimates of need should take into consideration that only those employees who wish to change their elections will re-register during the open season and that only about ten percent of employees are expected to do this.

SF 2809 is being revised, but the old edition should be used until supplies are exhausted.

C. New Form BRI 41-117. This new booklet, entitled Open Season Instructions and General Information, will explain the open season to employees. It will also list all plans and describe to whom they are available, and will contain an expanded restatement of the "Facts About All Plans" which are in the present brochures but which are being omitted from the new ones. (Information about specific benefits will, of course, continue to be carried in the separate brochures of the respective plans.)

D. Materials to be Issued to All Employees. Every employee eligible to change his election during the open season is to be given:

1. The new booklet BRI 41-117
2. A revised brochure (BRI 41-24) describing the Government-wide Indemnity Benefit Plan
3. A revised brochure (BRI 41-25) describing the Government-wide Service Benefit Plan , together with the applicable Basic Surgical-Medical Benefits Folder (fee schedule) . Local Blue Cross-Blue Shield Plans are responsible for furnishing these folders to installations
4. A revised brochure for each group- or individual-practice plan (if any) available to the employee in the particular area.

Installations will not make general distribution of brochures describing employee organization plans. These will be mailed direct to employee organization members by the Commission. However, each agency will be supplied with employee organization plan brochures for redistribution to installations for issue to any employee who requests one. Each installation is responsible for assuring that an employee receives an employee organization plan brochure if he requests it. Employee organization plan brochures should be stocked in strategic places (with SF 2809) so that any employee who requests one can quickly obtain it.

E. Time of Distribution. Brochures and other materials will be delivered to agencies as they are printed. It is hoped that all materials will have been delivered no later than the first week in September. Agency redistribution schedules should be arranged so that field installations have all their materials as soon thereafter as possible but no later than September 29, 1961. Issuance of materials to employees may begin as soon as an installation has its supply of all of the materials mentioned in paragraph D., including copies of employee organization brochures to be issued on request.

F. Schedule of Subscription Charges for Use of Payroll Offices. Some carriers will change their subscription charges. Therefore, the "Schedule of Subscription Charges effective July 1, 1960" presently in use by payroll offices will become obsolete for payroll periods beginning with the first pay period in November 1961. A new Schedule of Subscription Charges will be supplied agencies for redistribution to payroll offices in the same manner as the first edition.

VIII. OPEN SEASON PROCEDURES

A. Time of Filing Open Season SF 2809's. An employing office may accept (but not process) an open season SF 2809 before October 1, 1961. No open season SF 2809 should be accepted after October 16, 1961, unless the employing office determines, and so notes under "Remarks" on the SF 2809, that the employee was unable for cause beyond his control to timely take advantage of the scheduled open season.

B. Effective Date of Open Season Changes*. The effective date for open season SF 2809's is the first day of the first pay period which begins after October 31, 1961.** For open season SF 2809's belatedly filed and accepted as explained in (A), above, the effective date is the first day of the first pay period which begins on or after November 1, 1961, but not less than seven (7) days*** after the SF 2809 is received in the employing office.

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* These instructions do not apply to health benefit enrollments of new employees who happen to register for the first time during the open season. Such new enrollments will be made effective as provided in the group health benefit regulations for new enrollees.

** Except, as provided in regulation 89.4(b)(1), for changes by employees who are not enrolled in a plan and are in a non-pay status during the entire pay period preceding the first one beginning after October 31, 1961. (See page 1 of these instructions).

*** See footnote top of Page 10

*** The 7-day wait is a change from the present 14-day wait required by the Group Health Benefits Regulations. This, as well as other changes, will result from a general amendment of the regulations to be effective November 1, 1961. The amended regulations will be published in the Federal Register in the month of October, 1961.

C. Where Employee Wishes Not to Change His Election.

1. Employees who wish to make no change in their previous elections need do nothing. "No Action" on the part of an employee will result in continuance of his prior registration. If he is registered as enrolled, he continues under the same plan, option, and type of enrollment (family or self only).

2. All changes in benefits and charges made by a plan for the new contract term will apply to employees in that plan who do not change their elections. Where the plan has changed the subscription charges for an enrollment code number for the new contract term, payroll action must be taken and payroll records must be changed to reflect the new withholding for those employees continuing in the same enrollment code number.

D. Where Employee Wishes to Change His Election. Employees who wish to change from not enrolled to enrolled, or wish to change plans, options within a plan, or type of enrollment, must complete and file SF 2809 with their employing office. In general, open season SF 2809's will be processed as are other changes in election, with the following procedural variations and requirements:

1. The number of the event permitting the change, to be shown in Part D of SF 2809, is 1 (one); the date of the event may be omitted.

2. If an employee changes from one option to another, or changes from self only to family (or the reverse) within the same plan -- that is, if the first two digits of the enrollment code number in Parts B and D remain the same -- it is necessary to strike through the preprinted carrier's control number on the open season SF 2809 and insert the employee's existing carrier control number. No SF 2810 should be prepared in these cases.

3. If an employee changes from one plan to another plan, -- that is, if either of the first two digits of the enrollment code number in Parts B and D changes -- the preprinted carrier's control number on the open season SF 2809 applies to his new plan and should be retained. SF 2810 should be prepared to notify the losing carrier of the "Change in Plan" with a check in Part C and the losing carrier's control number in Part A, Item 3. If the open season SF 2809 is timely filed, the effective date to be entered on SF 2810 is the last day of the pay period immediately preceding the first pay period in November 1961. The "Original to Enrollee" part of this SF 2810 should not be given to the employee .

/Note: For the open season only, if changes in plans are sufficiently numerous to require daily processing of many SF 2810's to the same carrier, notices to that carrier may, at the option of the employing office, be processed in batches of about 25 on one SF 2810, as follows:

a) On the one SF 2810 --

i) In Part A, complete Items 5 and 7 and put the name of the losing plan (e.g., Service Benefit, Indemnity Benefit, etc.) in Item 6.
ii) Check Part C
iii) Under "Remarks" in Part H, say, "(insert number of employees, e.g., 25) multiple open season terminations due to changes from your plan - see attached list."
iv) Certify, as usual, in Part I

b) Prepare list, in duplicate, showing in columnar arrangement, for each of the approximately 25 employees terminating coverage with the carrier:

Employee's name	Date of birth	Carrier Control Number	Enrollment Code Number

If this procedure is used, one copy of the list should be attached to the carrier and payroll office copies of the SF 2810 as their action copies. The "Original To Enrollee" and "Quadruplicate To Employing Office" parts of the SF 2810 may be destroyed. The copy of the open season SF 2809 electing the change in plans, retained by the employing office, will suffice to show the transaction./

E. Need for Prompt Processing of Open Season Changes. Employing offices are urged to give high priority to handling changes and to processing SF 2809's and SF 2810's to payroll offices quickly -- on the same day they are received or the day after, if possible. Payroll offices should also process and send them to carriers on a daily basis. The usual weekly transmittals do not apply to the open season changes. It is important that a losing carrier be notified well in advance of the effective date of a termination of enrollment by reason of a "Change in Plan" so that the carrier does not guarantee or give benefits to an employee after his enrollment is terminated. This is particularly critical in open season changes since the carrier does not have the customary 31-day temporary extension of coverage during which to process the termination. It is also important to the employee that a gaining carrier be notified of the new enrollment so that the employee may promptly receive his identification cards evidencing his new coverage.

F. Changing Payroll Records. Payroll offices should adjust their controls for the enrollment changes and rate changes after the carrier's copies of SF 2809 and SF 2810 have been transmitted. In lieu of noting in Item 5 of Part F of SF 2809 that payroll action has been taken, the payroll office need only post the SF 2811 report No. which is used to transmit the document to the carrier. Particular care should be taken in withholding and reporting the proper subscription charges for the first pay period which begins on or after November 1, 1961.

G. Identification Cards. Payroll offices will no longer have the responsibility of handling ID cards furnished by the carriers for new or changed enrollments. ID cards will be mailed to the employee's home address directly by all carriers. This change in procedure will become effective in advance of the open season on October 1, 1961. Carriers which furnish medical expense record kits will send a kit with the ID card, thus making it unnecessary for the employing office to do so.

H. Transfers, Retirements, and Deaths During Open Season. Procedures governing transfers, retirements, and deaths will be published in a later Bulletin.

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